DEPAR	TMENT OF HEALTH	HAND HUMAN SERVICES /	1	(1111		04/29/2011
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	15 -	- 4	31 ((///		APPROVED
I STATEMEN	T.OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIPLE CONSTR	HICTION /		0938-0391
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILE		loonida ((X3) DATE SI COMPLE	TED
		445487	B. WING		<u></u>	0.4/2	7/2011
NAME OF F	PROVIDER OR SUPPLIER		l's	TREET ANDRE	SS, CITY, STATE, ZIP CODE	0412	112011
CHRISTI	AN CARE CENTER O	F JOHNSON CITY, INC		140 TECHNO	LOGY LANE		
	Orașe dell'Elifo	F JOHNSON CITY, INC			ITY, TN 37604		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	lD di		OVIDER'S PLAN OF CORRECT	TIÓN	
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREFIX	(EAC	H CORRECTIVE ACTION SHO	ULDERF	COMPLETION
		as is Livin Ting har ordination)	TAG	CROSS	REFERENCED TO THE APPR DEFICIENCY)	OPRIATE	DATE
F 164	402 40/-) 400 75/	140 B = 1 - 1 - 1 - 1		+			
SS=D		(4) PERSONAL ENTIALITY OF RECORDS	F 16	4 Disclaime	er for Plan of Correction		1
33-0	T KIVAC I CONFID	ENTIALITY OF RECORDS		Preparat	ion and/or execution of t	bio Dian as	1
	The resident has th	e right to personal privacy and		Correction	n does not constitute an	nis Plan of	1
	confidentiality of his	or her personal and clinical			ment by Christian Care Co		1
	records.	personal dita omnoci		Johnson	City of the truth of the fa	ete allogad	1
		NO. A		or conclu	sions set forth in the sta	tement of	1
	Personal privacy inc	cludes accommodations,		deficienc	les. Christian Care Center	of John	1
	medical treatment,	written and telephone		son City 1	les this Plan of Correction	n colely	- 1
	meetings of family s	ersonal care, visits, and and resident groups, but this		because	t is required to do so for	continued	
	does not require the	facility to provide a private		state lice	nsure as a health care pr	ovider	
	room for each resid	ent.		and/or fo	r participation in the Me	dicare/	
	TOP NOOM-SEEDINGSEE	50 - 1-30 - 100 f		Medicaid	program. The facility do	es not	
	Except as provided	in paragraph (e)(3) of this		admit tha	t any deficiency existed	orior to, at	
1	section, the residen	may approve or refuse the		the time	of, or after the survey. Th	ne facility	
Ī	release of personal	and clinical records to any		reserves	all rights to contest the s	urvev	
1	individual outside th	e facility.		findings t	hrough informal dispute	resolution.	
I	The resident's right	to refuse release of personal		formal ap	peal and any other appli	cable legal	
	and clinical records	does not apply when the		or admini	strative proceedings. Thi	s Plan of	
	resident is transferre	ed to another health care		Correctio	n should not be taken as	estab-	
	institution; or record	release is required by law.			y standard of care, and t		
1	-11.4079.00	100 000 0000 00000		submits t	hat the actions taken by	or in	
ĺ	The facility must kee	ep confidential all information		response	to the survey findings far	exceed	1
	the form or store	dent's records, regardless of		the stand	ard of care. This docume	nt is not	
	release is required b	methods, except when by transfer to another		intended	to walve any defense, leg	gal or	
	healthcare institution	i; law; third party payment		equitable	in administrative, civil o	r criminal	- 1
	contract; or the resid	lent.		proceedir	ngs.		
				1			
							
	This REQUIREMEN	T is not met as evidenced		F 164			
	by: Based on medical re	soord roulous share		Christian	Care Center of Johnson	ta	
	and interview the fo	ecord review, observation, cility failed to ensure privacy		heliever i	Care Center of Johnson C s current practices were	ity in	
	during a treatment fr	or one (#2) of eighteen			e with the applicable sta		
	residents reviewed.			care but	n order to respond to th	ic citation	
1				from the	surveyors, the facility is t	akina +ha	8
- 1	The findings include	d:			additional actions:	aking the	
ABORATORY	DIRECTOR			Tomowing			
NORTORY	UNECTURE OR PROVIDE	ROSUPPLIER REPRESENTATIVE'S SIGN	ATURE	1.	TITLE	/0	KE) DATE
n	16		/	dminis	herfore	5/1	([]]
ny deficiency	statement ending with a	h asterisk (*) denotes a deficiency which	h the institu	lon may be ev	rused from correcting provide	na it in data-	alord that

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event 1D:5|\$611

Facility ID: TN9011

If continuation sheet Page 1 of 17

IDENTIFICATION NUMBER:				(X3) DATE S	(X3) DATE SURVEY COMPLETED	
	445487	B. WING_			7/2011	
	F JOHNSON CITY, INC	1	40 TECHNOLOGY LAN	TATE, ZIP CODE IE	1/2011	
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	TIVE ACTION SHOULD BE CED TO THE APPROPRIATE	(X5) COMPLETION DATE	
Resident #2 was acceptuary 18, 2011, Intracranial and Introsteomylelitis, and Observation on Aprileve aled resident #2 window. Further ob (Licensed Practical resident's abdomen insulin 6 units without Interview on April 26 hall, with LPN #3, oclosed during the acceptual with the example of the facility must consider a comprehensive, a reproducible assess functional capacity. A facility must make assessment of a resident assessment of a resident assessment by the State. The acceptance in the following: Identification and decustomary routine; Cognitive patterns; Communication; Vision; Mood and behavior Psychosocial well-behavior in the continence;	Imitted to the facility on with diagnoses including aspinal Abscess, Hypertension. Il 25, 2011, at 5:10 p.m. Il 25, 2011, at 5:10 p.m. Il 29, 2011, at 5:10 p.m. Il 29, 2011, at 5:20 p.m. Il 29, 2011, at 5:20 p.m., in the servation revealed LPN Nurse) #3 exposed the and administered Humulin R ut closing the blinds. In 2011, at 5:20 p.m., in the confirmed the blinds were not diministration of the insulin. In REHENSIVE Induct initially and periodically ccurate, standardized sment of each resident's exident's needs, using the at instrument (RAI) specified seessment must include at emographic information; patterns; eing; and structural problems;	F 164	On 4/27/11, LPN a regarding resident of closing window administering insustaff was in-service. Nursing on 5/5/11 privacy for resident residents receiving of any form. Identification of O Potential to be Aff Due to the nature residents have the affected. Systematic Change Licensed Nurses w Director of Nursing the need to provide closing of blinds, winsulin injections of new Licensed N the need for full pring any type of injections of the Director of Nurses w Monitoring The Director of Nurses of the need Nurses for are administering the proceduring the proceduring the proceduring will report Performance Improveded the need to provide the proceduring will report the proceduring the proceduring the proceduring will report the proceduring the procedu	is a was counseled to privacy and importance blinds when alin. Licensed Nursing and by the Director of a regarding providing at #2 and any other as injections/treatments. Ither Residents with fected of this practice, current a potential to be Besides ere educated by the gron 5/5/11 regarding the privacy, including when administering are treatments. Education curses will also include rivacy when administer-section or treatment. It is a provided in the privacy of the privacy of the privacy when administer-section or treatments to the privacy of the priva		
Disease diagnosis a	and health conditions;					
	ROVIDER OR SUPPLIER AN CARE CENTER O SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From pa Resident #2 was ac February 18, 2011, Intracranial and Intr Osteomylelitis, and Observation on Apr revealed resident #2 window. Further ob (Licensed Practical resident's abdomen insulin 6 units witho Interview on April 25 hall, with LPN #3, o closed during the ac 483.20(b)(1) COMP ASSESSMENTS The facility must cola a comprehensive, a reproducible assess functional capacity. A facility must make assessment of a res resident assessment by the State. The a least the following: Identification and de Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior Psychosocial well-b Physical functioning Continence;	A45487 ROVIDER OR SUPPLIER AN CARE CENTER OF JOHNSON CITY, INC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 Resident #2 was admitted to the facility on February 18, 2011, with diagnoses including Intracranial and Intraspinal Abscess, Osteomylelitis, and Hypertension. Observation on April 25, 2011, at 5:10 p.m. revealed resident #2 lying on the bed next to the window: Further observation revealed LPN (Licensed Practical Nurse) #3 exposed the resident's abdomen and administered Humulin R insulin 6 units without closing the blinds. Interview on April 25, 2011, at 5:20 p.m., in the hall, with LPN #3, confirmed the blinds were not closed during the administration of the insulin. 483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication, Vision, Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems;	A BUILDIN A BUIL	A BUILDING 445487 A BUILDING 8. WING AND CARE CENTER OF JOHNSON CITY, INC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 Resident #2 was admitted to the facility on February 18, 2011, with diagnoses including Intracranial and Intrasplinal Abscess, Osteomylelitis, and Hypertension. Observation on April 25, 2011, at 5:10 p.m. revealed resident #2 plying on the bed next to the window. Further observation revealed LPN (Licensed Practical Nurse) #3 exposed the resident's abdomen and administered Humulin R insulin 6 units without closing the blinds. Interview on April 25, 2011, at 5:20 p.m., in the hall, with LPN #3, confirmed the blinds were not closed during the administration of the insulin. 483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: identification and demographic information; Customary routine; Cognitive patterns; Communication, Vision; Mood and behavior patterns; Psychosocial well-being; Mood and behavior patterns; Continence; PREFIX JOHNSON GITY, TN 140 TECHNOLOGY LAND JOHNSON GITY, TN 210 TECHNOLOG	### A BULDING ### BUDDING ### BUDDING	

STATEMEN	T OF DEFICIENCIES	ON PROVIDENCE	77		 	ONI DIVID	. 0938-0391
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONS		TRUCTION	(X3) DATE SURVEY COMPLETED	
		445487	B. WING			04/2	7/2011
NAME OF F	ROVIDER OR SUPPLIER		5	TREET ADDR	ESS, CITY, STATE, ZIP CODE	, <u>, , , , , , , , , , , , , , , , , , </u>	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
CHRISTI		OF JOHNSON CITY, INC		140 TECHN	OLOGY LANE CITY, TN 37604		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EA	PROVIDER'S PLAN OF CORRECTIVE ACTION SH SS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 164	Continued From pa	age 1	F 16	4 + + - 4 -			
	February 18, 2011, Intracranial and Int Osteomylelitis, and Observation on Ap	l Hypertension. ril 25, 2011, at 5:10 p.m.		Medica Assista Mainte Laundry Coordir Clinical	ninistrator, Consultant I I Director, Director of N nt Director of Nursing, nance Director, Housek y Supervisor, MDS/Care nator, Director of Social Records Supervisor, Die er, and Activities Director	ursing, eeping/ Plan Service, tary	6/1/11
	window. Further of (Licensed Practical resident's abdomer insulin 6 units without Interview on April 2 hall, with LPN #3,	2 lying on the bed next to the bservation revealed LPN Nurse) #3 exposed the n and administered Humulin R but closing the blinds. 5, 2011, at 5:20 p.m., in the confirmed the blinds were not		, munug.	and Activities Direction		
F 272 SS=D	483.20(b)(1) COMF ASSESSMENTS	dministration of the insulin. PREHENSIVE	F 27	2 F 272			
	a comprehensive, a	enduct initially and periodically accurate, standardized sment of each resident's		believes complia of care, citation	n Care Center of Johnso its current practices we nce with the applicable but in order to respond from the surveyors, the the following additions	ere in standard to this facility	
	resident assessment by the State. The alleast the following: Identification and decustomary routine; Cognitive patterns; Communication; Vision;	sident's needs, using the nt instrument (RAI) specified assessment must include at emographic information;	- 1	Correcti An asses wander and a ca resident ventions behavio	ve Action for Targeted I ssment of Resident #11' ing behaviors was comp ire plan was completed t on 5/5/11, which inclu- s for this resident's wan rs.	Residents s leted for this des inter- dering	
	Continence;		3	Potentia Charts o	ation of Other Resident I to be Affected If residents who have w haviors were audited by	andering	

	(X8) DATE SURVEY COMPLETED	
04	27/2011	
DOOE	***	
F CORRECTION CTION SHOULD BE THE APPROPRIATE ICY)	(X5) COMPLETION DATE	
ctor was educated or on 5/9/11. The need to ensure ndering type bement of behaviors is been developed		
be reviewed by the review will be New admission ng type behaviors t and a care plan behaviors no later ission to the linator will audit to ensure that ssment on wand that approcess care planned. Admission ng type behaviors months. The MDS these findings to wement Completermination of his committee		
e it into it it is a sear in the	ctor was educated or on 5/9/11. The eneed to ensure ndering type bement of behaviors is been developed the residents' ents with wanderbe reviewed by the review will be. New admission ing type behaviors no later dission to the dinator will audit to ensure that issment on wanderbe care planned. Admission ing type behaviors months. The MDS is these findings to overent Comdetermination of his committee strator, Consultant	

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AND PLAN	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		TRUCTION	(X3) DATE SURVEY COMPLETED	
	· · · · · · · · · · · · · · · · · · ·	445487	B. WING	······································		04/2	7/2011
20 20		F JOHNSON CITY, INC	8	140 TECHN	IESS, CITY, STATE, ZIP CODE IOLOGY LANE I CITY, TN 37604		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE			
F 272 F 281 SS=D	Activities Room, recentering their room an ongoing concern. Interview with the A at 9:00 a.m. confirm were cognitively impand going into othe Interview with the A 2011, at 1045 a.m. been observed on sother resident's roo confirmed staff were redirect the resident Interview with the D the DON's office, A confirmed the facility assessment for carrinterventions for the behaviors. 483.20(k)(3)(i) SER PROFESSIONAL STAR SEQUIREMENT	vealed wandering residents and taking belongings was a for them. dministrator on April 27, 2011, ned staff were aware there paired residents wandering resident's rooms. ctivities Director on April 27, confirmed Resident #11 had several occasions going into ms. Continued interview a aware and could usually to another activity. irector of Nursing (DON), in oril 27, 2011, at 2:15 p.m., y had failed to provide an a planning and develop resident's wandering	F 27	Pharm Nursin Mainte Laundr Coordi Clinica Manag Christia believe compli- of care citatior	acist, Medical Director, Dg, Assistant Director, Housekery Supervisor, MDS/Care nator, Social Service Director Records Supervisor, Dieger, and Activities Directors its current practices we ance with the applicable but in order to respond from the surveyors, the g the following additional	ursing, Peping/ Plan ctor, tary r. re in standard to this facility	6/1/11
	and interview, the fa feeding set and the	ecord review, observation, acility failed to label a tube tube feeding container for one iteen residents reviewed.		On 4/2 tube fe were c	tive Actions for Targeted 7/11, the tube feeding se eding container for Resident out and the new set and tube feeding co	t and lent #1 tube	
	Resident #1 was ad	mitted to the facility on March			beled with the resident's		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5IS611

Facility ID: TN9011

If continuation sheet Page 4 of 17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MÜLTIPLE CONSTRUCTION A, BUILDING			(X3) DATE SURVEY COMPLETED	
		445487	B. WING_		04/2	7/2011	
		F JOHNSON CITY, INC	1	REET ADDRESS, CITY, STATE, ZIP CO 40 TECHNOLOGY LANE IOHNSON CITY, TN 37604			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRÉCEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 315 SS=D	Disease, Dysphagic Gastrostomy Tube. Medical record revidated April 1, 2011 via PEG (percutante) 70cc/hr (cubic company of the company of the cubic c	noses including Parkinson's a, Atrial Fibrillation, and ew of a physician's order revealed " Fibersource HN cous endoscopic gastrostomy) entimeters per hour)" il 25, 2011, at 11:15 a.m., 11:1	F 281	date, time started, and infus the standard of practice. Identification of Other Resid Potential to be Affected Current residents receiving thave the potential to be affected sets and tube feeding contain place for other residents in place for other residents in receiving enteral feedings to tube feeding sets were dated containers were labeled with name, date, time started and per the standard of practice. Systematic Changes Licensed Nurses were educa Director of Nursing on 5/5/1 need for labeling tube feeding tube feeding containers with name, date, time started, and rate per the standard of practice feeding containers with name, date, time started, and rate per the standard of practice feeding sets and tube feedings to the performance review and determination of compliance. This committee	ents with sube feeding ected. On tube feeding mers that were in the facility ensure that d and feeding mersidents' d infusion rate ted by the 1 regarding the ing sets and in the resident's d the infusion etice. rsing will audit months the eeding ment residents ensure that be feeding the resident's d infusion rate. report these Committee for fon-going		

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STATEMEN AND PLAN (T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI	DLTIPLE CONST	RUCTION	(X3) DATE SURVEY COMPLETED	
		445487	B. WIN	G		03/2	7/2011
	ROVIDER OR SUPPLIER AN CARE CENTER O	F JOHNSON CITY, INC		140 TECHNO	ESS, CITY, STATE, ZIP CODE DLOGY LANE CITY, TN 37604	1 04/2	7/20)1
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	K (EA	ROVIDER'S PLAN OF CORREC CH CORRECTIVE ACTION SHO S-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 281	Disease, Dysphagia Gastrostomy Tube. Medical record revidated April 1, 2011, via PEG (percutance) 70cc/hr (cubic composed of the composed of	noses including Parkinson's a, Atrial Fibrillation, and ew of a physician's order revealed "Fibersource HN cous endoscopic gastrostomy) entimeters per hour)" il 25, 2011, at 11:15 a.m., 1 in bed, a tube feeding pump Fibersource HN in a d with the resident's name, at the PEG tube through an tube feeding set.	F 2	Medica Assistar Mainte Laundry Coordir Clinical	strator, Consultant Phari I Director, Director of Nu It Director of Nursing, nance Director, Houseke y Supervisor, MDS/Care I nator, Social Service Dire Records Supervisor, Die er, and Activities Directo	eping/ Plan ctor, tary	6/1/11
F 315 SS=D	a.m., confirmed the with the resident's reinfusion rate as per 483.25(d) NO CATHRESTORE BLADDI Based on the resident sassessment, the fact resident who enters indwelling catheter i resident's clinical cocatheterization was who is incontinent of treatment and servicinfections and to resident's possible. This REQUIREMENT by: Based on medical resident's resident's possible.	ent's comprehensive cility must ensure that a the facility without an is not catheterized unless the andition demonstrates that necessary; and a resident of bladder receives appropriate ces to prevent urinary tract store as much normal bladder	F3	Christia believes complia of care, citation taking t Correct Residen appropriate UTIs according to the context of the context	n Care Center of Johnson its current practices we nee with the applicable but in order to respond from the surveyors, the he following additional a live Actions for Targeted t #9 is currently receiving the incontinent care to cording to policy and proyed by the Director of Nurne providing appropriate tent care.	ere in standard to this facility is actions: Residents g prevent acedures. ere sing	

FORM CMS-2587(02-99) Previous Versions Obsolete

Event ID: 5IS611

Facility ID; TN9011

If continuation sheet Page 5a of 17

STATEMENT OF DEFICIENCIES (X1) P AND PLAN OF CORRECTION ID	ROVIDER/SUPPLIER/CLIA ENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		ION ((X3) DATE SURVEY COMPLETED	
	445487	B. WING_			04/27/2011	
NAME OF PROVIDER OR SUPPLIER CHRISTIAN CARE CENTER OF JOH (X4) ID SUMMARY STATEMEN	1	14 J	10 TECHNOLOGY OHNSON CITY,	, TN 37604		
PREFIX (EACH DEFICIENCY MUST TAG REGULATORY OR LSC IDEN	BE PRECEDED BY FULL	-ID PREFIX TAG	(EACH CO	DER'S PLAN OF CORRECTION SHOUL RECTIVE ACTION SHOUL ERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 315 Continued From page 5 provide appropriate incon resident (#9) of eighteen in The findings included: Resident #9 was readmitt December 8, 2009, with of Atrial Fibrillation, Hemiple Left side. Medical record review of it dated March 28, 2011, reit frequently incontinent of be total assist for toileting. Observation on April 27, 2 resident's room, revealed (certified nursing assistant incontinence care to the in observation revealed both and assisted the resident bed. Continued observati removed the pants, and u #2 sprayed peri wash on it #1 cleaned the perineal ar rolled the resident to the le buttocks area without cha the wipe. Further observati placed brief on the reside gloves or disinfecting the (sheet and blanket) on the remote for the bed positio place the resident's stuffe Review of the facility's pol revealed "8washusi from front to back of the pstartingwiping from froi gloves and discard. 18. W	ed to the facility on liagnoses including gia and Hemiparesis the Minimum Data Set wealed the resident was ladder and required 2011, at 8:50 a.m., in the CNA #1 and CNA #2 t) providing esident. Continued CNA's donned gloves from wheelchair to the on revealed CNA #2 ntaped the brief, CNA he perineal area, CNA rea in a circular motion, eff side, cleaned the nging wipes or folding ation revealed CNA #2 nt., and without changing hands placed the linen e resident, adjusted the n, and continued to d animals in the bed. Icy Perineal Care ng gentle down strekes erineum10 nt to back17. Remove	F 315	Due to the name residents recithe potential Systematic C CNA staff wa Nursing on 5 provide incompation of the provide incompation of the provide in-serviced of with a return competency of the Director CNA staff per ensure that the followed. A 1 monitored dimonth for the Nursing will reformance review and discompliance. The Administ Medical Director Supervisor, Medical Services Social Services	cature of this practice, quiring incontinent caul to be affected. Changes as educated by the Director of Nursing will monitored in the facility policy is being a sample of CNAs will be a sample	rector of need to ag to the swill be care to eing will be e each ector of to the nittee for ong ists of armacist, sing, nte-nundry inator, cords	

STATEMEN AND PLAN (T OF DEFICIENCIES OF CORRECTION	(X1) PI	ROVIDER/SUPPLIER/CLIA ENTIFICATION NUMBER:		IULTIPL	E CONST	RUCTION	(X3) DATE SURVEY COMPLETED	
			445487	B. WIN	NG			04/2	7/2011
100000000000000000000000000000000000000	ROVIDER OR SUPPLIER AN CARE CENTER OF	JOH	NSON CITY, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 140 TECHNOLOGY LANE JOHNSON CITY, TN 37604					12011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST I	ÖF DEFICIENCIES BE PRECEDED BY FULL TIFYING INFORMATION)	ID PREFI TAG		(EA	ROVIDER'S PLAN OF CORRECT CH CORRECTIVE ACTION SHOT S-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 315	Interview with CNA 2011, at 8:55 a.m., CNA's had failed to providing appropriat	#1 and n the follow e inco	d CNA #2 on April 27, hallway, confirmed the the facility's policy for ntinence care and had disinfect hands after	F3	315			G.	
F 323 SS=D	as is possible; and e	/ISIOI sure the s as fi	V/DEVICES nat the resident ree of accident hazards	F3		believes complia of care, citation	n Care Center of Johnson its current practices we nce with the applicable s but in order to respond t from the surveyors, the he following additional a	re in standard to this facility is	
	by: Based on medical refacility investigations the facility failed to eplace and functionin resident and failed to prevent dislodgement one (#2) resident of The findings include Resident #8 was ad February 11, 2011, y	ecord in observation observati	ervation, and interview, safety devices were in revent falls for one (#8) ement interventions to intravenous line for en residents reviewed. to the facility on agnoses including I Fibrillation, Diabetes,			Residen for prop prevent approp Residen unrelate Identific Potentia Current	ve Actions for Targeted for #8 was re-assessed or per safety device needed falls. It was determinate safety device was in #2 has expired due to ed causes. Sation of Other Residents al to be Affected residents requiring safet avenous lines have the preceded.	n 5/10/11 d to led that n place. with y devices	

STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SI COMPLE	JRVEY TED
		445487	B. WING		04/2	7/2011
ARROANECUTERS &	PROVIDER OR SUPPLIER IAN CARE CENTER O	F JOHNSON CITY, INC	12	EET ADDRESS, CITY, STAT 40 TECHNOLOGY LANE OHNSON CITY, TN 37	E, ZIP CODE	
(X4) ID PREFIX TÄG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCEI	N OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
F 323	Medical record revion March 4, 2011, I with mats to floor, s bed9-29-10 Add s to pad alarm while (Medical record review Progress Note date revealed,"(resider of (reclined) G (gerifaintlyno red or brown of the post I November 9, 2010, from chair what cain place prior to the (reclined) G-chair' Review of the post I 2011, 6:20 p.m., revealedResident was injuries notedInterfunctioning at time of the post I 2011, 6:20 p.m., revealedResident was injuries notedInterfunctioning at time of the post I 2011, revealed in the post I 2011, revealed, "	nt was at high risk for falls. The work of the care plan reviewed evealed, "7/13/09 Low bed hortened cord on clip alarm to their cord clip alarm in addition up) in geri-chair" The work the Interdisciplinary di November 9, 2010, at discovered in floor in front chair Clip alarm sounding uised areas noted" The planned interventions were fall? Clip alarm (and) The valuation dated march 19, realed, " Resident fell: from observed on the floor (no) ventions in place and of the fall? (blank)" The work the Interdisciplinary di March 19, 2011, revealed, lent observed on floor on anying to get up Resident nes trying to get out of bed" The valuation dated April 19, Resident fell: from oor after daughter had put is laying on the floor by wheel or mat were in use. No	F-323	met with Resident in need for the safety was addressed. A caution, the resider reminded by the Di ask staff to assist woresident. Nursing staff was earned on 5/5/11 regarding that safety devices functioning to previously be utilizing arm gauze as the interved dislodgement of interved dislodgement of interved in the safety devices more if needed, to are in place. Monitoring Residents requiring intravenous lines work assistant Director of device audit will consafety device, and exist in place and function audit for intravenous lines work and that pris in place to prevenint avenous line. The performance Impromonthly for three monthly f	erdisciplinary Team #8's daughter. The device for the resident s a measure of nt's daughter was rector of Nursing to ith transfer of ducated by the DON g the need to ensure are in place and ent falls. The facility /hand boards and ention to prevent ravenous lines. The e to assess residents every two hours, or ensure safety devices safety devices and ill be audited by the f Nursing. The safety nsist of the type of ensure that the device tioning properly. The us lines will include roper assistance device at dislodgement of the These audits will be rector of Nursing and ector of Nursing to the vement Committee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
		445487	B. WING	·	04/2	7/2011	
\$450,000 CONTRACTOR OF THE CON	ROVIDER OR SUPPLIER AN CARE CENTER O	F JOHNSON CITY, INC		REET ADDRESS, CITY, STATE, ZI 140 TECHNOLOGY LANE JOHNSON CITY, TN 37604	P CODE		
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F 323	Daughter calledco fall" Interview on April 20 conference room, wand the Assistant Dundetermined if the functioning at the tip 2010, and March 15 confirmed the safet the time of the fall of Resident #2 was ad February 18, 2011, Intracranial and Introsteomylelitis, and Medical record review Progress Note date revealed, "New or (intravenous needle (left) wristSecured Medical record review Progress Note date revealed, "Entered INT that was inserted floorobtained orderorearm for antiblotic Medical record review Progress Note date "Res. (resident) of clothing on floor INT	place to prevent further falls? punseled (and) notified of all of punseled (and) notified of all of punseled (and) notified of all of pursely	F 329	DEFICIEN	or of Nursing, rsing, lousekeeping/ S/Care Plan Social Service, or, Dietary	6/1/11	
	Medical record revie Progress Note date	ew of the Interdisciplinary d March 21, 2011, 2:15 p.m.,					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPP IDENTIFICATION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A: BUILDING		(X3) DATE S COMPLE	(X3) DATE SURVEY COMPLETED	
		445487	B. WING_		04/2	7/2011	
	ROVIDER OR SUPPLIER AN CARE CENTER O	F JOHNSON CITY, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 140 TECHNOLOGY LANE JOHNSON CITY, TN 37604				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 323	revealed, "INT pla (p.m.) Observed re pulled it out" Interview on April 2 Assistant Director of room, confirmed no implemented to ensisted.	aced into (left) wrist11:50 p sident INT on side of bedhad 6, 2011, at 2:40 p.m., with the of Nursing, in the conference onew interventions had been sure the resident's INT was	F 323	E 229			
F 328 SS=D	A83.25(k) TREATM NEEDS The facility must er proper treatment as special services: Injections; Parenteral and enter Colostomy, uretero Tracheostomy care; Tracheal suctioning Respiratory care; Foot care; and Prostheses. This REQUIREMENT by: Based on medical resules and Regulati Nurses, observation failed to ensure der to performing a proeighteen residents The findings include Resident #2 was accommodated.	stomy, or lleostomy care; It is not met as evidenced ecord review, review of the ons of Licensed Practical, and interview, the facility monstrated competency prior cedure for one (#2) of reviewed. ed: dmitted to the facility on with diagnoses including	F 328	Christian Care Center of believes its current pract compliance with the approf care, but in order to recitation from the survey taking the following add. Corrective Action for Tar Resident #2 has expired causes. Identification of other Repotential to be Affected. Current residents with P potential to be affected. Systematic Changes LPNs were educated on Director of Nursing regard only those tasks for which prepared and has demonst to perform. Direct care for the performed by a Regis The RN will supervise detthe LPNs regarding PICC.	cices were in blicable standard espond to this ors, the facility is itional actions: Egeted Residents due to unrelated esidents with ICC lines have by this practice. 5/5/11 by the rding performing the each has been estrated ability or PICC lines will tered Nurse. legated duties of		

STATEMENT OF DEFICIENCIES (X1) F AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONST	RUCTION	(X3) DATE S COMPLE	
	,	445487	B. WING			04/2	7/2011
CHRIST		OF JOHNSON CITY, INC	1	40 TECHN	ESS, CITY, STATE, ZIP CODE OLOGY LANE CITY, TN 37604		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATÈMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EA	PROVIDER'S PLAN OF CORRECT CH CORRECTIVE ACTION SHO SPREFERENCED TO THE APPE DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 328	Osteomyelitis, and Medical record revirecapitulation order through April 30, 20 (antibiotic) 2gm (gr (normal saline)ini Observation on April (Licensed Practical PICC (peripherally flush revealed the fresident's room, war gloves, cleaned the alcohol, flushed the saline, changed glo PICC line with alcohol with the IV (intraver line. Review of the Rules Practical Nurses, Redated June 2007, repractical Nurses and delegated functions handle by education which supervision is care situation, the liperform only those prepared and has demonstrated in the individual competency in the process of Nursing, confirmed no docur	Hypertension. lew of the physician's is dated April 15, 2011, 2011, 2011, revealed, " Cefepime ams) in 50 ml (milliliter) NS travenousevery 8 hours" fil 26, 2011, with LPN Nurse) #1 performing the inserted central catheter) line following: LPN #1 entered the eshed the hands and donned a port of the PICC line with a port with 20 milliliters normal eshed the hands and donned a port of the PICC line with a port with 20 milliliters normal eshed, and attached the tubing hous) antibiotic to the PICC is and Regulations of Licensed alle 1000-2-,04 (3) (a) and (c), evealed, "(a) Licensed is liable if they perform they are not prepared to and experience and for so not provided. In any patient icensed practical nurse should fasks for which each has been lemonstrated ability to perform hing activities requiring greaters, the following criteria must be all must demonstrate	F-328	lines in quarter perform supervisive regarding to commit of on-go consists Pharma Nursing Mainter Laundry Coordin Clinical	ector of Nursing will months facility for 3 months, ly, to ensure that RNs are sing direct care for these sing delegated duties of the selines. These find these lines. These find the Performance tree for review and determing compliance. This cort of the Administrator, Corist, Medical Director, Di, Assistant Director of Numance Director, Houseker, Supervisor, MDS/Care Plator, Director of Social Screen, and Activities Director.	then lines, and the LPNs adings will mination mittee onsultant rector of arsing, eping/ lan ervice, ary	6/1/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPFLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	RÖVIDER OR SUPPLIER AN CARE CENTER O	F JOHNSON CITY, INC	1.1	EET ADDRESS, CITY, 10 TECHNOLOGY L OHNSON CITY, T	ANE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORR	I'S PLAN OF CORRECT ECTIVE ACTION SHOU ENCED TO THE APPRO DEFICIENCY)	LD BE CO	(X5) MPLETION DATE
F 328 F 371 SS=E	to performing the P the antibiotic, 483.35(i) FOOD PF STORE/PREPARE. The facility must - (1) Procure food froconsidered satisfact authorities; and (2) Store, prepare, under sanitary conductors and the sanitary conductors and the sanitary conductors are stacked pantibility and intensure stacked pantibility and intensure stacked pantibility and intensure stacked pantibility and intensure stacked pantibility.	ICC line flush or administering ROCURE, //SERVE - SANITARY Im sources approved or tory by Federal, State or local distribute and serve food litions IT is not met as evidenced liew, review of the menus, erview, the facility failed to s were clean, failed to ensure separated from food, and	F 328	believes its cur compliance with standard of cal respond to this surveyors, the following addit Corrective Acti The quarter paranitized on 4/Manager, accoording to the complex of the com	Center of Johnson rent practices were the applicable re, but in order to scitation from the facility is taking the tional actions: Ion for Targeted Reference was washed and (26/11 by the Dietarding to facility possessing solution to the same and the content of the content was solution to facility possessing to facility possessing to facility possessing solution to the content of the content o	e in esidents I ary licy.	
	Used for one meal. The findings include Observation on Aprithe CDM (Certified one stacked quarter small amount of del and a 5 liter bucket (sanitizing solution) next to six covered Review of the facility revealed, "!t is the	Il 25, 2011, at 10:35 a.m., with Dietary Manager) revealed pan on the drying rack with a oris on the side of the pan, with 3 liters of saniquat sitting under the serving line bowls of corn flakes. y policy, Pots and Pans, policy of this facility to clean id pans to maintain sanitary		the beets was a Manager to a 4 The 2 oz. scoop super mashed with a 4 oz. sco Manager on 4/ Identification of Potential to be Due to the national	of Other Residents	etary /26/11. eve the aced with	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		RUCTION	(X3) DATE SURVEY COMPLETED	
	<u> </u>	445487	B. WING_			04/2	7/2011
CHRIST	,	OF JOHNSON CITY, INC	1	40 TECHN	ESS, CITY, STATE, ZIP COD OLOGY LANE CITY, TN 37604		
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F 371	the Dietary Manag quarter pan neede sanitizing solution food. Observation on Aptray line revealed a serve the beets, at to serve the super Review of the facil 4 z (ounce) spood Interview on April 2 Registered Dieticia ounce scoop (spood beets, and a 4 ounthe super mashed Interview on April 2 Dietary Manager, i approximately four 483.65 INFECTION SPREAD, LINENS The facility must expressed in the prevent the of disease and infection Control Pasage, sanitary and to help prevent the of disease and infection Control Program under where the program under where the sanitary and the program under where the program under where the sanitary and the sanitary and the sanitary and the program under where the sanitary and the	26, 2011, at 10:35 a.m., with per, in the kitchen, confirmed the ed to be washed, and the was not to be sitting next to oril 26, 2011, at 5:00 p.m., of the a 3 ounce scoop was used to a 2 ounce scoop was used mashed potatoes. Ity's menus revealed, "Beets le" 26, 2011, at 5:00 p.m., with the an, in the kitchen, confirmed a 4 odle) was to be used for the ace scoop was to be used for potatoes. 26, 2011, at 5:00 p.m., with the n the kitchen, confirmed teen trays had been served. N CONTROL, PREVENT stablish and maintain an rogram designed to provide a comfortable environment and development and transmission ection.	F 371	Dietary Dietary the new accord solutio that fo approp scoop a Monito The Die assista will mo cleaned sanitizi and that approp scoop a items v for thre will rep Perforr for revi on-goir consist Pharma Nursing Mainte Laundr Coordin Clinical	Astaff was educated by Manager on 4/28/11 ed to ensure that pansing to facility policy, the is not left near food ods should be served with the size and appropriate size and appropriates of the Registered I onitor to ensure that part of the size and appropriate size and appropriate foods are served with price of the Registered I onitor to ensure that part foods are served with price size and appropriate s	regarding are washed at sanitizing items, and with the iate type of . The colicy, that hear food, the iate type of . These ekly basis y Manager he of mmittee of mmittee . Consultant , Director of Nursing , keeping / e Plan al Service , vietary	6/1/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE S COMPLE	URVEY ETED
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	ROYDER OR SUPPLIER AN CARE CENTER O	F JOHNSON CITY, INC	1	BEET ADDRESS, CITY, STATE, ZIP 40 TECHNOLOGY LANE OHNSON CITY, TN 37604	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATÉMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 441	(2) Decides what p should be applied to (3) Maintains a reconstructions related to in (b) Preventing Spread (1) When the Infect determines that a represent the spread isolate the resident (2) The facility must communicable dise from direct contact will trough (3) The facility must hands after each dinand washing is indeprofessional practice (c) Linens Personnel must have transport linens so infection. This REQUIREMENT by: Based on medical rand interview the facontrol strategies were sidents (#14, #2)	rocedures, such as isolation, o an individual resident; and ord of incidents and corrective affections. and of Infection tion Control Program esident needs isolation to of infection, the facility must the prohibit employees with a case or infected skin lesions with residents or their food, if ansmit the disease. It require staff to wash their rect resident contact for which dicated by accepted is. Indie, store, process and as to prevent the spread of the spr	F 441	Christian Care Center of J believes its current practic compliance with the appl of care, but in order to recitation from the surveyor taking the following additions of Corrective Action for Target On 4/28/11, LPNs #2 and in-serviced by the Director the need to disinfect and, prior to and after medical stration and during and at a clean dressing change. On 4/27/11, the restroom removed from the water ADON, and the fountain with disinfected. On 5/10/11, resident who placed their the fountain was educate Administrator to place the the wall hanger when finited to be Affected. Current residents receiving requiring dressing change potential to be affected. Any person utilizing the wall has the potential to be affected.	ohnson City ces were in icable standard spond to this rs, the facility is ional actions: teted Residents #4 were r of Nursing on for wash hands cion admini- fter performing h key was fountain by the vas immediately the male testroom key in d by the te key back on shed. sidents with g medication or s have the	
	Resident #14 was a	admitted to the facility on 9, with diagnoses including				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE S COMPLE	(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER CHRISTIAN CARE CENTER OF JOHNSON CITY, INC				REET ADDRESS, CITY, STATE, ZIP C 40 TECHNOLOGY LANE OHNSON CITY, TN 37604	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE EAPPROPRIATE	(X5) COMPLETION DATE	
F 441	Hypertension, Museffects of Cerebral Observation during 2011, at 11:00 a.m. #2 (licensed practical administer medication from the resident's room, arresident. Continued do administering medication for the medication to the medication of the medication to the medication of the medic	cle Weakness, and Late Vascular Accident. I walk through on April 25,, in the hallway, revealed LPN cal nurse) preparing to tion to resident #14. Continued ed LPN #2 retrieved e medication cart, went to the digave medication to the digave medication to the digave medication to the digave medication or after administering he resident. #2 on April 25, 2011, at 11:05 of confirmed had not or or after administering he resident. dmitted to the facility on August noses including Congestive I Fibrillation, Muscle	F 441	Licensed Nursing staff was by the Director of Nursing regarding the proper procesanitizing or washing hand to facility policies. Licensed will be in-serviced upon hir annually by the DON on prowashing per facility policy. On 5/10/11, the restroom I was lowered by the Mainted Director to provide easier a residents in wheelchairs to replace the restroom key. Monitoring Medication administration dressing changes will be au Assistant Director of Nursin (Monday thru Friday) for for and then monthly for three audit will include daily obset three medication administron each shift and two dress (Monday thru Friday) to enhand washing. The Consumpharmacist will assist in meadministration audits on me for three months. The Housekeeping Supervisithe drinking fountain in the daily for one month to ensuare not placed in the drinking The audit will be reviewed Administrator and reported Performance Improvement	con 5/5/11 redure for ds according Nursing staff e and oper hand- key hanger renance recess for remove and and clean dited by the reduction of ration passes sing changes sure proper relatant dication onthly visits remove that items ing fountain. by the dito the		

STATEMENT OF DEFICIENCIES (X1) F AND PLAN OF CORRECTION ((X1) PR	OVIDER/SUPPLIER/GLIA ENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE S COMPLE	URVEY TED
			445487	B. WING		04/2	7/2011
NAME OF PROVIDER OR SUPPLIER CHRISTIAN CARE CENTER OF JOHNSON O			1	REET ADDRESS, CITY, STATE, ZIP CO 140 TECHNOLOGY LANE JOHNSON CITY, TN 37604			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST B	OF DEFICIENCIES IE PRECEDED BY FULL TIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 441	unused supplies and bag, opened the resident freeded16. Rem Interview with LPN: a.m., in the hallway gloves and disinfect scissors and after president. Resident #2 was act February 18, 2011, Intracranial and Introsteomyletis, and Household LPN (Lice washed hands in recount to the hall to the Humulin R insulin 6 the resident's room, where the room is resident's room, where the room is resident's room, where the room is resident to the resident's room, where the room is resident's room, where the room is resident to the	d placesident's n the sident's n the sident's n the sident's n the sident's confinited hard lacing medical laci	April 26, 2011, at 9;20 med had not removed had not removed had after disinfecting the dressing on the to the facility on agnoses including Abscess, insion. O11, at 5:10 p.m. ractical Nurse) #3 #2's bathroom, came atton cart, prepared the applied gloves, entered based the door, exposed disadministered the washing the hands after or. , at 9:00 a.m., in the Director of Nursing, to be washed after r to administering the		The hand washing audits for administration and dressing be reviewed by the Director and results reported to the Filmprovement Committee modern committee consists of the Activity of Nursing, Assistan Nursing, Maintenance Direct Housekeeping/Laundry Super MDS/Care Plan Coordinator, Social Service, Clinical Record Dietary Manager, and Activity	change will of Nursing Performance onthly. This dministrator, ical Director, t Director of or, ervisor, Director of ds Supervisor,	6/1/11

PRINTED: 04/29/2011 FORM APPROVED OMB NO. 0938-0391

IND PLAN OF CORRECTION IDENTIFICATION NUMBER:				RUCTION	(X3) DATE SURVEY COMPLETED	
38	445487	B, WI	vè		04/27/2011	
ROVIDER OR SUPPLIER AN CARE CENTER O	F JOHNSON CITY, INC		140 TECHNO	LOGY LANE		
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL		IX (EAC	H CORRECTIVE ACTION SHOU	ULD BE	(X5) COMPLETION DATE
2011, at 11:20 a.m. on one side of the vone for wheelchair observation revealering was laying in the Interview with the A Nursing) at the time	, in the main hallway revealed vall was two water fountains, access. Continued a key with a wooden key be regular water fountain, DON (Assistant Director of of observation confirmed the	F	441	DEFICIENCE		N.
	¥					
	ROVIDER OR SUPPLIER AN CARE CENTER O SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From pa 2011, at 11:20 a.m. on one side of the y one for wheelchair observation reveale ring was laying in th Interview with the A Nursing) at the time	F CORRECTION IDENTIFICATION NUMBER:	A BU 445487 ROVIDER OR SUPPLIER AN CARE CENTER OF JOHNSON CITY, INC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 16 2011, at 11:20 a.m., in the main hallway revealed on one side of the wall was two water fountains, one for wheelchair access. Continued observation revealed a key with a wooden key ring was laying in the regular water fountain. Interview with the ADON (Assistant Director of Nursing) at the time of observation confirmed the	ROVIDER OR SUPPLIER AN CARE CENTER OF JOHNSON CITY, INC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 16 2011, at 11:20 a.m., in the main hallway revealed on one side of the wall was two water fountains, one for wheelchair access. Continued observation revealed a key with a wooden key ring was laying in the regular water fountain. Interview with the ADON (Assistant Director of Nursing) at the time of observation confirmed the	A BUILDING A BUILDING B. WING ROWDER OR SUPPLIER AN CARE CENTER OF JOHNSON CITY, INC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 16 2011, at 11:20 a.m., in the main hallway revealed on one side of the wall was two water fountains, one for wheelchair access. Continued observation revealed a key with a wooden key ring was laying in the regular water fountain, Interview with the ADON (Assistant Director of Nursing) at the time of observation confirmed the	A BUILDING A BUILDING A BUILDING B. WING COMPLE A BUILDING COMPLE A BUILDING COMPLE A BUILDING B. WING COMPLE A BUILDING A BUILDING COMPLE A BUILDING A BUILDING COMPLE A BUILDING PROVIDER CROCK PETANE CRO

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:5IS611

Pacility ID: TN9011

If continuation sheet Page 17 of 17